Napa Valley Podiatry Group

Sky P. Shanks, DPM, AACFAS
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Demographics (Please Print)

Date: __________
Full Name (Last, First MI): _________________________, ____
Date of Birth: ______________ Age: ________ Sex: M F Social Security Number: _______________________
Home Address: ____
City/State: ____ Zip: ______________________
Phone #: (_____) _____-_________ Work Phone #: (_____) _____-_________
E-mail: _________________________ @ ______________ Primary Language: ____________________

Race (circle one):

African American or Black	American Indian or Alaska Native	Asian
Native Hawaiian or Pacific Islander	White	Not Specified

Ethnicity (circle one):
Hispanic Non-Hispanic

Emergency Contact: ___________________________ Relationship: ______________
Phone #: (_____) _____-________

Do you have a legal guardian or healthcare power of attorney? Yes No
If yes, Name: _____________________________________ Relationship: _____________
Phone #: (_____) _____-________

Primary Care Doctor: ____ Phone #: (_____) _____-________
Referring doctor/ Individual: ____ Phone #: (_____) _____-________
Pharmacy: ____________________________ Location: _____________________ Phone #: (_____) _____-________

Insurance Information

	Primary Insurance	Secondary Insurance
Insurance Company Name:	____________________________________	____________________________________
Subscriber Name:	____________________________________	____________________________________
Subscriber/Member #:	____________________________________	____________________________________
Subscriber D.O.B:	____________________________________	____________________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made with our office.

Insurance authorization and assignment:

I hereby authorize Sky P. Shanks, D.P.M. to furnish information to insurance carriers concerning my illnesses and treatments and to my referring physician if so requested. I hereby assign to the physician all payments for my medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature: ____ Date: _________________________

Please initial if you will allow photographs to be taken of you to document your care and/or for educational purposes.
_______ Thank You.